## **Smiles For Children Transportation Complaint Form**

(\* Required fields)

| Name of Dental Office:  |  | *Telephone Number  |  |
|---|--|--|--|
| Form Completed by   | *Title   | *Fax Number  |  |
| ntal Office Street Address:   |  | City   |  |
| ient (Recipient) Name   |  | Medicaid ID Number:  |  |
| me of Transportation Provider if known:   |  |  |  |
| ture of Complaint: Please check   | all that apply   |  |  |
| Medicaid Recipient NO-SHOW for  | · DENTAL Appointment   |  |  |
| <br>Transportation Issue Known by Dental Of   | ffice please check all that  | apply below:   |  |
| Transportation Provider was LATE or I Scheduled Arrival Time Patient did not schedule transportation wrong type of vehicle sent for trip (e.g. Told by LogistiCare at Time Description of the priver did not follow special instruction Patient or Family not notified of change Incident/Accident (e.g., vehicle accident Other Issues with LogistiCare (please e Ongoing or unresolved issue(s) that have Specifics of Incident | Actual Arrival Time in time therefore missed age, needed wheel chair van, that "No Proverse Time picked up and given for pick up, drop the in provider, scheduled pint, incident on vehicle, etc. explain below)  we been reported but are stated in the state of | ppointment needed stretcher, etc) vider Available" to do the trip Arrived off or return trip ick up or return time ) Injuries? Yes NO ill occurring. |  |
|   |  |  |  |
| First, FAX this form to the QA at your Lo   |  |  |  |

5/6).